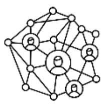
# Set Your Lunch on FHIR

Lunch and Learn Series Session 3: FHIR 101

Thurs. July 9, 2026



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# Set your Lunch on FHIR 🔥

## Session 3 ~ FHIR 101

July 9 2026

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Next Level Health Innovations

# Focus Today:

## Impact of FHIR on Health Center Roles and Responsibilities

Responsibilities that may change

- API connections
- Access controls
- Data sharing decisions
- Following up and entering information

## What else can you see changing?

# What FHIR implementations or API connections has your team taken on?

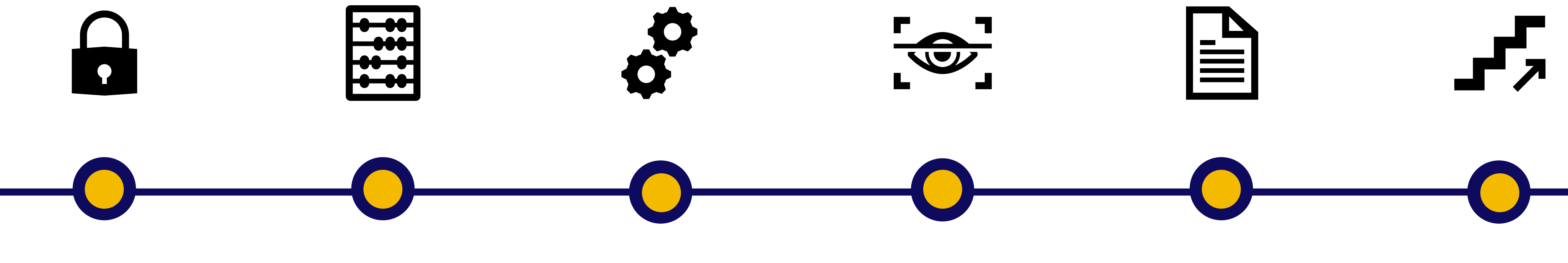
What has your experience been with that process?

How did you decide to go ahead with it?

How did you manage access and/ or security concerns?

What about ongoing maintenance?

# Why these changes?



- Governance around privacy, security, consent, etc.
- Different accountability processes
- API configuration and maintenance
- Third-party app access
- Data release and access policy decisions differ
- Escalation processes

# ONC and CMS Continues to Make Clear that FHIR and Patient Access are Priorities Through Rulemaking and Enforcement

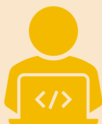
Through HTI-5 Proposed Rule, ONC seeks to make FHIR APIs the new for certified EHR technology (CEHRT). ONC envisions these requirements supporting creative AI-enabled interoperability solutions; prioritizing FHIR-based APIs that:

- enhance automation and performance;
- move beyond read-only interactions; and
- expand the scope of data available; specifically, data that supports clinical efficiency, patient-centered care, and timely reporting.

In the past year or so, ONC has also stepped up enforcement actions (though generally not on healthcare providers) against those actors who are identified as blocking access to information by patient or their providers.

CMS is starting to incentivize/ encourage/ require FHIR by payers as we have discussed, and as they set minimum health IT standards for model participation they are likely to align with ONC/ CEHRT.

# Roles and Responsibilities: Before and After



Historically, organizations may have mainly governed HL7 v2 feeds, CCDA or document exchange, file transfers, and interfaces, which meant external apps were **not** querying patient data in real time and allowed for some case-by-case decision making.

With FHIR, the organization is effectively exposing a set of data, so governance has to cover app or client registration (*how do we know this app or client should have access via our FHIR API?*), scopes, token handling, resource-level access, and what happens when an app requests data that is technically available but not appropriate to disclose.

As such, ownership for API configuration, onboarding, vetting, and audit review all become central to the operating model rather than something that's done at launch and then periodically thereafter.

# What does this look like?

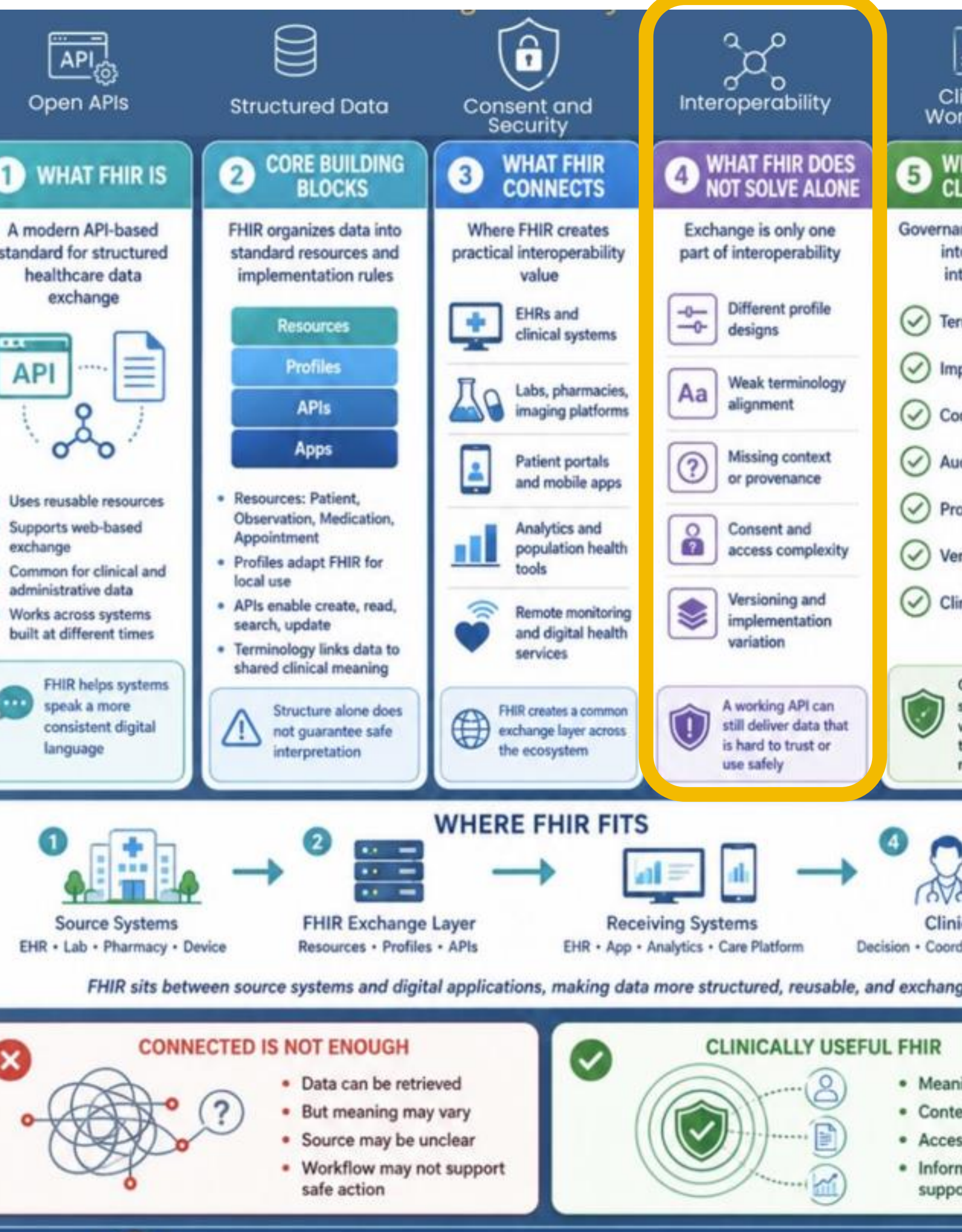
Pre-FHIR, a health center might have governed a nightly export through an IT team and ROI processes, and limited external variability.

A FHIR-enabled environment moves the health center toward allowing multiple patient apps, payer apps, and partner APIs access different resources continuously.

This means there must be formal decisions – in advance! With big privacy and security implications!-- on who approves each app, who monitors logs, and who responds when a privacy concern is raised.

In order to comply with 21st Century Cures Act Information Blocking rules, this access must be provided “without unnecessary delay”, which means any manual review must be timely and not be a barrier to patient access.

Dr. Connor Shields posted this on LinkedIn.



# How does your team see these potential changes?

- Particularly as you are having to maintain each reality at the same time?
- Managing changes in what teams need to be focused on/ consider?
- Consent documentation and processes?
- Access and authorization?

**Have roles or titles shifted? Will they?**

**Privacy, compliance, and security staff (mostly within IT) will probably feel more demands related to app review, consent, managing permissions, and audit oversight, since FHIR creates more direct access paths to data and provides more real-time access.**

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This may feel like an even bigger change as health centers continue to try to balance their own cybersecurity risks, HIPAA, 42 CFR Part 2 (if it applies), and state privacy regulation with patient access and FHIR API based exchange.

# What Creates Change?

**Ability**
*Knowledge and Skills*

**Motivation**
*Desire and drive to act*

**Opportunity**
*Context that supports action*

## What is the path of least resistance?

These changes may seem too hard to communicate, too hard, too risky– particularly if your team is burned out with change, risk averse, not particularly tech forward, etc.

## If that is the case, what remains possible?

# Which FHIR pathway are we dealing with and what will it require of us?

| If you are thinking about... | You are probably dealing with... | What to Consider |
|---|---|---|
| Patients using apps to access or share their own data | Patient Access / SMART on FHIR | **Is this already supported by the EHR or portal? What does the patient control?** |
| Prior authorization, payer care coordination, payer data sharing, or claims/clinical data exchange | Payer APIs | **Which payer? Which API? Where in the workflow?** |
| Referrals, care coordination, clinical data exchange with hospitals, HIEs, CBOs, or other providers | Provider-to-provider exchange built on the FHIR Standard and Provider APIs | **Who is the partner? What data is needed? Is there a shared IG or platform? How will exchange be monitored?** |
| Dashboards, panel management, QI, or reporting | Internal or vendor-supported FHIR/Bulk FHIR | **Can the EHR or population health platform expose the right data reliably?** |

# What else can FHIR shift?

FHIR can also change roles/ responsibilities related to data retrieval, validation, release, reporting, and monitoring. Likely change is that some tasks that were once manual, local, or behind the scenes become standardized, API-driven.

Staff who currently or have historically tracked down information or results could do less of that chasing if labs, meds, notes, referrals, and/or care summaries are available through FHIR-enabled workflows or apps.

EHR analysts and informaticists may take on **more** mapping, profiling, validation, and change management, because FHIR requires careful normalization of local data into FHIR resources and profiles.

Quality and reporting staff may move from manual abstraction/ cleanup toward data governance, measure education, exception review, and data validation, because more reporting pipelines may be fed directly from structured APIs.

# Examples of Changing Roles/ Responsibilities

Referral coordinators who used to spend time tracking down lab results may instead focus on exceptions, missing data, or escalation when the FHIR feed fails or returns incomplete information.

Quality analysts who previously assembled reports from spreadsheets and chart review may spend more time validating resource mappings, reconciling measure logic, and confirming that source data is trustworthy before automated reporting.

Program managers for grants or special initiatives may shift from manually compiling submissions to overseeing the definitions, data flows, and governance rules that feed those submissions.

If you could move *one* FHIR effort forward in the next 12–18 months, which would you pick?

What assistance would be most helpful? What do you need?